NCMC

National Capital Medical Center

National Capital Medical Center

Supplemental Information

District of Columbia
and
Howard University

October 27, 2005

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I. Introduction

In November 2003, Council proposed and passed emergency legislation directing the Mayor to negotiate an agreement with Howard University to build a new hospital on U.S. Reservation 13**.** In January 2004, the Mayor and the University submitted a Memorandum of Understanding (MOU) to Council. This MOU stated that the District would enter into a long-term lease with Howard University for 9 acres of land on U.S. Reservation 13. On that land, Howard University would build, own and operate a new 200 to 300 bed hospital with Level One trauma capabilities, a medical office building, and a research complex. The Council unanimously approved the MOU in May 2004.

In July 2005, the District and Howard released a proposal to Council and the public that described the need for a new full-service hospital on the eastern side of the District, provided an overview of the NCMC and its services, presented a conceptual site and facility design, and offered projected operating financials. Since then, the District has been working closely with Howard University to finalize the costs and project schedule for the new facility, develop the financing package, and detail the plans for transforming the Reservation 13 site. The District has also received input from the public at a number of public meetings held in Wards 5, 6, and 7 and at the Democratic State Committee.

This document is intended to supplement the comprehensive plan released in July 2005 to respond to additional issues, including more information on costs, financing, project schedule, and Reservation 13 site preparation. It also includes an "in-progress" draft of the Exclusive Rights Agreement, which is currently being negotiated between the District and Howard University. In addition, the document will discuss some areas that are indirectly related to the NCMC, such as the District's plan for delivering key public health services, the District's relationship with Greater Southeast Community Hospital, the Medical Homes Initiative to promote primary care, and the Mayor's forthcoming proposal to expand health coverage to District residents from 200-400% of the federal poverty level.

II. Overview of the National Capital Medical and key services

Vision

The establishment of the National Capital Medical Center (NCMC) on Reservation 13, as a modern, comprehensive, state of the art tertiary medical center, with Level One trauma, in alliance with community physicians and clinics has great potential to enhance the delivery of healthcare services for the benefit of a significant portion of the District's population.

The NCMC will provide a single standard of high quality, world-class comprehensive care for all, without regard to ability to pay. The vision for the NCMC includes the following elements:

- Integrated system of care that includes hospital and community-based services
- All digital hospital with state of the art medical equipment, patient safety and clinical information systems
- Backbone for community-based systems of care with a focus on prevention, wellness and web-based management information systems for secure data sharing
- Training programs for new physicians and allied health professionals
- Robust response capabilities and other special components to strengthen the region's homeland security infrastructures
- Thought leader in clinical and applied research that advances medicine, diagnosis, treatment and outcomes
- Three public health research centers:
    - Aging
    - Nursing
    - Clinical Information Systems
- An economic engine to foster growth and vitality on the East side of the District.

The National Capital Medical Center will be an integrated medical complex containing three major components: a hospital, a medical office building, and a research center. The medical center will also provide additional services for the surrounding community. Public health services will be offered within the complex or in close proximity. The NCMC will serve as a major hub for the community health network (see Appendix H for NCMC vision document).

Hospital

The hospital will be a primary teaching facility for the Howard University School of Medicine. As such, it will provide tertiary-level services. Departments will include:

Aging	Neurosurgery
Allergy/Immunology	Mental Health
Anesthesia	Obstetrics and Gynecology
Cardiovascular Medicine	Ophthalmology
Dermatology	Orthopedics
Ear, Nose, and Throat	Pathology
Emergency Services	Pediatrics
Endocrinology, and Metabolic Diseases	Physical Medicine and Rehab
Family Practice	Plastics and Reconstructive Surgery
Gastroenterology	Podiatry
General Surgery	Pulmonology
Hematology/Medical Oncology	Radiation Oncology
Infectious Diseases	Renal
Internal Medicine	Trauma
Level I and II Nursery	Urology
Neurology	

The NCMC will include rooms for inpatient and outpatient surgeries and other procedures. It will focus on minimally invasive procedures and provide comprehensive ambulatory surgery.

The hospital will provide four major types of beds for acute inpatient care: medical/surgical, obstetrics and gynecology, pediatric, and psychiatric. It will also include a secure unit with a separate entrance for corrections patients. The NCMC will participate in the new Department of Mental Health program to care for involuntary, acute mental health patients. The NCMC will include a sizable 24 hour, 7-day a week emergency and trauma service, with capacity for a minimum of 50,000 emergency room and approximately 4,000 trauma visits.

In addition, the NCMC will provide other outpatient diagnostics services such as radiology and laboratory. Community-based physicians will be able to refer their patients for these diagnostic services.

Medical office building
A medical office building adjoining the hospital will house community physicians. These physicians will provide outpatient primary care and specialty care to community residents. They will admit patients to the NCMC and use the NCMC procedure rooms. Community-based practitioners will be able to refer patients to NCMC-based specialists for consultation.

Research center
The NCMC will also develop facilities and services on its campus as a continuum of its public health, research, and education mission. Major research programs may include Aging, Clinical information systems, and Nursing.

Other community services
In addition, the NCMC will offer and provide an array of services as a community benefit, to improve the quality of life for area residents. Such services may include:

- Restaurant
- Health club
- Pharmacy

Community health network for underserved populations
Through thoughtful, well-planned services, the NCMC expects to significantly increase accessibility of the full continuum of care to underserved District populations. This will allow a currently underserved population to access the level of care appropriate to their need, whether it be primary and preventive care, specialty services, diagnostic and ancillary services, urgent care or emergency services.

The NCMC will offer wellness, prevention and an array of services that contribute to healthier lifestyles and positive health outcomes, particularly for those diseases and conditions that are highly prevalent within minority communities. Services will include nutrition counseling, support groups, physical fitness classes and other related programs aligned with the public health and prevention research focus of Howard University.

A number of public health services have traditionally been offered on Reservation 13 (the former DC General site). These services, specifically a tuberculosis clinic, an STD clinic, a detoxification center and a primary care medical home will continue to be offered within close proximity of the NCMC. These services will be provided by the District Government or contracted out to the NCMC or other community providers.

In addition, the NCMC will work with several community health groups to eliminate health disparities through provision of primary and secondary preventive services designed to reduce ambulatory sensitive hospitalizations and to improve outcomes of those systemic conditions that adversely impact the surrounding population.

Specific initiatives will include:

- Active participation in the DC Medical Homes initiative.

- Provision of secondary and tertiary care services to community providers.

- Cooperation with DC Medical Homes' Information Technology initiative to implement an information technology interface with the community health network to provide easy access to lab, radiology and consultation reports from any web based computer.

- Real-time access to clinical results reporting, appointment scheduling, reminder follow-up and patient education information at the hospital, in the caregiver's office, and in the patient's home.

- Coordination, communication and faster results reporting thus contributing to faster turn around times for diagnosing and treating patients, leading to an overall improvement in health outcomes.

Serving as the hub of a well-coordinated care delivery system, the NCMC will provide specialty, diagnostic, urgent and emergency care to meet the needs of Medical Homes primary care patients.

Howard University Hospital and the NCMC

Howard University Hospital and the NCMC will become a two-campus healthcare system under unified governance. The coordinated approach will provide high quality healthcare. The proposed organizational structure will maximize efficiency and use of resources.

The services that Howard University plans to offer at the NCMC are based on the needs of the community. The greatest unmet need is for Level One trauma care. Therefore, the University will move its Level One trauma and requisite related services--neurosurgery, cardiovascular surgery, and orthopedic surgery--from Howard University Hospital to the NCMC.

Given the current proximity of the University's pediatric and adolescent services to Children's Hospital, the University will also consider moving these services to the relatively underserved area where the NCMC will be located. The Level III NICU (Neonatal Intensive Care Unity), which supports the obstetrics service, may also be relocated.

In addition, under the Exclusive Rights Agreement (ERA) between the District and Howard University, the University will move 250 of its licensed beds from Howard University Hospital to the National Capital Medical Center and keep the total bed count

of both hospitals under 482, the current number of beds licensed to Howard University Hospital. (See draft ERA in Appendix A)

III. Project Costs

Over the past several months, the District and Howard University have completed analysis to determine a more precise estimate of the total NCMC project costs. Howard University's architects developed a more detailed facility program. The District hired cost estimators to determine the cost to build the program. Then we made a number of adjustments to the cost estimator figures to reduce the total cost of the project and determine the costs to be shared between the District and the University.

Howard University and its architects, in consultation with the District, developed an initial program for the NCMC based on industry norms and market studies completed by the Lewin Group (detailed in the July 2005 NCMC Proposal). The projected bed distribution, assuming all private beds (with the exception of the nurseries), is as follows:

NCMC Bed Distribution

Department/Unit	Count
NURSING	
Medical/Surgical Nursing Unit	60
Intensive/Critical Care Nursing Unit	60
Open Heart Surgery Cardiac ICU	12
Isolation Care Unit	8
Sleep Disorder Unit	4
WOMEN & CHILDREN	
Gynecological Nursing Unit	6
Post Partum Nursing Unit	8
Pediatric Nursing Unit	10
Pediatric Intensive Care Unit	10
LDR or LDRP Unit	10
Levels I & II Nursery	10
Level III Nursery - Neonatal ICU	6
SPECIALTY NURSING	
Observation/Clinical Decision Unit	10
Correctional Care Nursing Unit	20
Psychiatric Nursing Unit (Locked)	8
Psychiatric Nursing Unit (Open)	8
Total Facility Beds	**250**

Source: Perkins & Will and Marshall Erdman

In addition, Howard University's architects projected square footage by department by allocating percentages of the total square footage of the proposed facility based on industry norms. They developed three options, a minimum square footage, an optimum square footage, and a program target.

Departmental Program Range

All values are in Building Gross Square Feet (BGSF)

Department (with notes)	Minimum Area	Optimum Area	Program Target at 0.97 of Optimum
NURSING			99,328
Medical/Surgical Nursing Unit	32,880	36,000	
Intensive/Critical Care Nursing Unit	44,880	48,000	
Open Heart Surgery Cardiac ICU	8,976	9,600	
Isolation Care Unit	5,984	6,400	
Sleep Disorder Unit	2,200	2,400	
WOMEN & CHILDREN			43,553
Gynecological Nursing Unit	3,750	3,900	
Post Partum Nursing Unit	5,000	5,200	
Pediatric Nursing Unit	6,250	8,000	
Pediatric Intensive Care Unit	7,500	8,000	
LDR or LDRP Unit	11,000	8,000	
Levels I & II Nursery	2,300	7,000	
Level III Nursery - Neonatal ICU	1,950	4,800	
SPECIALTY NURSING			31,525
Observation/Clinical Decision Unit	5,500	5,500	
Burn Intensive Care Unit	0	0	
Rehabilitation (licensed) Nursing Unit	0	0	
Correctional Care Nursing Unit	15,000	16,000	
Psychiatric Nursing Unit (Locked)	5,200	6,000	
Psychiatric Nursing Unit (Open)	4,800	5,000	
DIAGNOSTIC & TREATMENT			
EMERGENCY	48,813	49,700	51,701
Ambulance Services	3,600	3,600	
AMBULATORY CARE	7,500	7,500	7,275
AMBULATORY SURGERY	17,000	25,000	30,070
Delivery (C-Section)	5,500	6,000	
Birthing Center	0	0	
SURGERY	39,568	40,150	38,946
DIAGNOSTIC IMAGING	30,069	35,150	34,096
LABORATORY			16,733
Reference Laboratory	10,000	10,500	
Decentralized Laboratories	4,500	4,500	
Morgue	2,000	2,250	
CARDIOLOGY SERVICES			6,018
Cardiac Catheterization	2,400	2,580	
Catheterization Prep/Recovery	384	384	
Non-Invasive Diagnostic and Testing	384	300	
Pulmonary Function Testing	360	240	
Open Heart Surgery	2,616	2,700	
ONCOLOGY SERVICES			50,440
Radiation Therapy	21,250	46,250	
Infusion Therapy	2,000	2,000	
Diagnostic & Testing	3,750	3,750	

THERAPIES			17,218
Respiratory Therapy	2,500	2,500	
Physical Therapy	5,500	5,500	
Occupational Therapy	2,000	2,000	
Speech & Audiology	1,500	1,500	
Activities of Daily Living (ADL)	1,500	1,250	
Recreation Therapy	1,500	1,250	
Kidney Dialysis	2,000	3,750	
CLINICS (not in M.O.B.)			27,888
Clinics	6,250	6,250	
Clinics with offices	10,500	10,500	
Specialty Clinics	10,500	12,000	
SUPPORT			
DIETARY/FOOD SERVICE	16,250	18,750	18,188
CENTRAL STERILE SUPPLY	3,750	4,500	4,365
MATERIALS MANAGEMENT	7,500	8,750	8,488
PHARMACY – INPATIENT	4,500	4,500	4,365
PHARMACY – OUTPATIENT	2,000	2,000	1,940
HOUSEKEEPING	4,500	5,000	4,850
MAINTENANCE/BIOMEDICAL	2,500	3,000	2,910
ENGINEERING ADMINISTRATION	2,000	2,500	2,425
SECURITY	750	750	728
INFORMATION SYSTEMS	1,250	1,250	1,213
LAUNDRY	5,000	5,500	5,335
EDUCATION			
EDUCATION & CLASSROOMS	6,250	6,250	6,063
AUDITORIUM (Movie Theater)	6,000	6,250	6,063
PUBLIC HEALTH EDUCATION	6,250	6,500	6,305
ADMINISTRATION			
ADMINISTRATION	3,750	5,500	5,335
NURSING ADMINISTRATION	2,500	2,500	2,425
ADMITTING	2,250	2,250	2,183
BUSINESS OFFICE/FINANCE	5,000	7,000	6,790
MEDICAL RECORDS	3,750	5,500	5,335
HUMAN RESOURCES	2,000	2,000	1,940
QUALITY ASSURANCE	2,000	2,250	2,183
MEDICAL STAFF SERVICES	1,250	1,250	1,213
SOCIAL SERVICES	1,250	170	1,698
VOLUNTEERS	1,250	1750	1,698
RESEARCH			
MEDICAL RESEARCH	5,000	5,000	4,850
CLINICAL TRIALS	1,250	3,750	3,638
INFRASTRUCTURE			
PUBLIC AREAS	8,750	10,000	9,700
STAFF FACILITIES	2,000	2,000	1,940
COMMUNICATIONS/PBX	850	750	728
PLANT OPERATIONS	56,250	62,500	60,625
VERTICAL CIRCULATION	18,750	18,750	18,188
HORIZONTAL CIRCULATION	31,250	31,250	30,313
STAGING SPACE	6,250	6,250	6,063
FUTURE EXPANSION	6,250	6,250	6,063
UNASSIGNED	6,250	6,250	6,063
TOTAL HOSPITAL BGSF	644,864	728,854	706,988

Source: Perkins & Will and Marshall Erdman

The District then worked with two construction firms skilled at providing detailed cost estimates for hospital construction projects, Turner/Tompkins and BE&K. The two firms each independently developed cost estimates, which were within a few percentage points of each other. They then worked together to agree on a "consensus" cost-per-square-foot estimate for each of the major components of the NCMC. The firms also agreed on a projected level of inflation between October 2005 and the time the NCMC project will be priced for construction, likely in 2007.

To reach a total cost to be shared between the District and Howard University, we made a number of adjustments to the Cost Estimators' figures, including several major design changes to reduce total project costs.

First, we eliminated underground parking in favor of a smaller, 1000-space above-grade parking structure. The traffic study commissioned by the District and completed by Parsons Brinckerhoff found that a number of comparable hospitals in urban areas, including the George Washington Hospital facility in DC, have 1000 parking spaces or fewer.

COMPARABLE HOSPITAL PARKING ANALYSIS

Hospital Name	George Washington University Hospital	Howard University Hospital	California Pacific Medical Center - Davis Campus*	Maryland General Hospital	Northwest Hospital & Medical Center	Proposed NCMC
Location	Washington, DC	Washington, DC	San Francisco, CA	Baltimore, MD	Seattle, WA	Washington, DC
Beds**	371	482	341	300	281	250
Parking spaces	1,083	1,575	333	800-1000	1,078	1,500
Spaces/Bed	3.26	5.41	0.98	3.33	3.84	6.00
Parking structures (occupants)	1 (patients/ visitors/ students/ staff)	2 (staff)	1 (all)	2 (patients/ visitors)	1 (all)	1 (all)
Underground structures	0	0	0	0	0	1
Surface Lots	0	4 (visitors/ staff)	0	0	7 (6 staff, 1 patients)	0
Nearest rail station (blocks)	0	2	N/A	2	N/A	1
Bus lines servicing facility	10	7	3	8	1	6
Transit share (employees, %)	Unknown	Unknown	19	Unknown	8	N/A
Carpooling /Vanpooling share (employees, %)	Unknown	Unknown	19	Unknown	20	N/A

Source: Parsons Brinkerhoff

Given NCMC's location near a metro station and six major bus routes, it is expected that most employees will take public transportation. It is also expected that many patients, especially the elderly, will arrive via medical vanpool transportation. In order to mitigate potential traffic impacts of the hospital, it is necessary to control the number of parking spaces and encourage public transportation. In addition, the construction of a surface garage, likely located immediately to the East of the NCMC across the Hill-East River Road, will eliminate traffic issues that would have been caused by an underground parking garage with an entrance on Independence Avenue. Queuing along Independence Avenue would have disrupted commuter traffic. The City Administrator's Office has requested the use of 525,000 square feet of Sports and Entertainment Commission land immediately adjacent to the NCMC site for the purposes of building a parking garage (see letter in Appendix B). The replacement of underground parking with a surface lot and the reduction of the number of parking spaces from 1500 to 1000 reduced the total cost of the NCMC, including soft costs, by $33,450,000.

Second, we reduced the hospital square footage per bed. The original estimated size of the NCMC was 3100 square feet per bed for a total of 775,000 square feet, including atrium and retail space. As the team looked at comparable facilities built in the U.S. in recent years, we realized that this figure was higher than average. Very few new academic medical centers have been built from scratch in the US in the past decade. The following are the most relevant comparables identified by the team:

COMPARABLE TEACHING HOSPITAL PROJECTS

Facility	Location	Beds	Square Feet	SF/bed
National Capital Medical Center - Original design	Washington DC	250	775,000	3,100
UCLA- Westwood Campus	Los Angeles, CA	525	1,200,000	2,286
Arrowhead Regional Medical Center	Colton, CA	383	920,000	2,402
Cook County Hospital	Chicago, IL	464	1,300,000	2,802
Unidentified Case Study	Unidentified	560	1,310,000	2,339

Source: Marshall Erdman/Perkins & Will; Turner/Tompkins

We found that the average square foot per bed of the identified teaching hospital projects was roughly 2400. As a result, the team decided to reduce the square footage per bed of the NCMC. By eliminating the atrium and retail space, we were able to bring square feet per bed down to 2800. We then further reduced the size of the hospital facility by imposing an additional cap on square footage, down to 2400 square feet per bed, or a total of 600,000 square feet. This cap will essentially function as a budget for the hospital, by necessitating a final design that meets the size constraint. We feel that this size is attainable, given the comparables. The total cost savings from elimination of atrium and retail space and reduction of square feet per bed to the 2400 benchmark was $69,552,875**,** including soft costs.

Third, we subtracted out the costs that will be borne wholly by Howard University. Of the total cost of the Medical Center, the District and Howard have agreed that the shared costs will include the hospital, the parking structure, and "soft costs" of the hospital and parking, such as architectural and engineering fees, furnishings, medical equipment, and administration. Howard University has agreed to separately fund the medical office and research portions of the medical center.

Finally, we made a small technical adjustment to subtract a portion of the streetscape and city park costs added by the cost estimators, which are already reflected in the Anacostia Waterfront Corporation's site preparation budget (see chapter VI).

A summary of the major cost reductions due to design changes is as follows:

NATIONAL CAPITAL MEDICAL CENTER
COST REDUCTIONS

Cost reductions, including soft costs

Parking*	$ 33,450,000
Atrium/retail**	$ 17,171,000
Square Footage reduction**	$ 52,381,875
Total Reductions	$ 103,002,875

* Smaller (1000 space) surface garage to replace underground parking
** To be eliminated

The total shared project costs of the NCMC, including the above adjustments, are expected to be $381,936,000**.** This estimate reflects expected inflation through 2007, the year that the construction contract will likely be bid. Each party has agreed to contribute 50% of this amount, or $190,968,000 each. In addition, each party will set aside $10,600,000 as a 10% design contingency. The District will contribute all or a portion of the contingency only if the total shared project costs are more than $381,936,000 and Howard University contributes an equal sum of contingency funds. The comparison of the original cost estimate and the revised cost estimate is as follows:

COST ESTIMATE
COMPARISON OF ORIGINAL AND REVISED DESIGNS

Design Element	Original Assumption	Unit Cost	Original Estimate	New Assumption	Revised Estimate
250-Bed Hospital	705,000 SF	$325/SF	$ 229,125,000	600,000 SF	$195,000,000
Parking Garage	1500 cars underground	$30,000/Car	$ 45,000,000	$15,000/Car 1000 car surface	$ 15,000,000
Retail Shell Space	40,000 SF	$160/SF	$ 6,400,000	eliminated	$ -
Atrium	30,000 SF	$300/SF	$ 9,000,000	eliminated	$ -
Streetscape Allowance	14 Acres		$ 2,000,000		$ 2,000,000
TOTAL - Construction Cost:			$ 291,525,000		$212,000,000
Soft Costs					
Architecture/Engineering	10%		$ 29,152,500		$ 21,200,000
Hospital Equipment	35%		$ 80,193,750		$ 68,250,000
Furniture Fixtures & Equip	7%		$ 16,038,750		$ 13,650,000
Owner Administration	1.5%		$ 4,372,875		$ 3,180,000
TOTAL - Soft Costs:			$ 129,757,875		$106,280,000
PROJECT TOTAL IN 2005 DOLLARS*			$ 421,282,875		$318,280,000
INFLATION TO 2007	20%		$ 84,256,575		$ 63,656,000
PROJECT TOTAL IN 2007 DOLLARS*			$ 505,539,450		$381,936,000
DISTRICT SHARE OF PROJECT COSTS (50%)			$ 252,769,725		$190,968,000
CONTINGENCY	10%		$ 29,152,500		$ 21,200,000
DISTRICT SHARE OF CONTINGENCY (50%)			$ 14,576,250		$ 10,600,000
MAXIMUM TOTAL DISTRICT CONTRIBUTION			$ 267,345,975		$201,568,000

Notes:

1. A/E fees are 10% of hospital construction costs
2. Equipment is 35% of hospital construction costs
3. F F & E is 7% of hospital, MOB & Research Construction Costs
4. Owner Administration is 1.5% of Total Construction Cost

*Does not include finance costs

Source: Consensus Cost Estimate was developed by Turner/Tompkins and BE&K based on the preliminary plans and space program developed by Marshal Erdman/Perkins & Will.

IV. Project Schedule

The NCMC project is expected to take roughly five and one half years to complete. The preparation of the site for the construction of the hospital, including demolition of existing buildings, environmental remediation and grading, is expected to begin early in 2006, with the site completed and ready to turn over to Howard University in 18 months by June of 2007. During that same 18-month period, the University will complete all architectural and engineering work and secure financing for its portion of the project costs. Construction is expected to begin in January 2008 and be completed by July of 2010. A Medical Office Building, housing physicians of all specialties is expected to be completed as much as a year prior to the full hospital. The detailed project schedule is included in Appendix C**.**

V. Capital Financing Plan

District Plan

The District has agreed to pay for 50% of the capital project costs of the National Capital Medical Center (NCMC), excluding the cost of the medical office building and research facilities. This projected cost, developed by the District's team of cost estimators, adjusted to account for expected inflation by the time the facility construction is bid in 2007, is $381,936,000**.** The District's 50% contribution comes to $190,968,000. The District will also agree to contribute a contingency of up to 10% of the District share if the total budget of the NCMC rises above $381,936,000 and Howard University contributes a contingency equal to the District's.

The District is interested in pursuing financing options for the NCMC that would either obviate or minimize District debt financing of this project. Three sources of funding have been identified for the District's portion of the project costs:

- **Tobacco Settlement Funds** – The District will engage in an additional Tobacco Settlement Securitization transaction similar to the one executed by the District in 2001, with the potential to generate funds of approximately $100 million based on current market conditions. This securitization transaction could be completed within a relatively short period of time and thus could yield revenues to be used in early phases of the project.

- **Surplus Revenues** – $100 million of surplus revenues, i.e., operating surpluses, will be allocated and appropriated from the fund balance as "PayGo" capital funding for the NCMC project.

- **New Market Tax Credits** – Any balance of funding will be derived from the sale of New Market Tax Credits, a federal program that provides subsidies to institutions that invest in underserved areas. Under this program, the District would seek to form a pool of Community Development Enterprises, which are the recipients of New Market Tax Credits from the federal government, to invest in the NCMC project. These investors would be guaranteed a return on their investment by the tax credits, and their investment dollars would reduce the amount that the District would have to finance itself.

As indicated above, it would be preferable to avoid or minimize debt financing for this project; however, the District would have the option to utilize debt financing for NCMC to the extent that the options indicated above are not utilized or do not produce funds sufficient to cover the entire cost.

Howard University Plan

Howard intends to use tax-exempt revenue bonds to finance its portion of the NCMC. The bonds will be issued through a governmental conduit of the District used by other District nonprofit organizations for similar financings in order to qualify for tax-exempt status.

The NCMC's obligation to repay the bonds will be secured by hospital revenues and a debt-service reserve fund funded from bond proceeds and equal to one year's debt service payment. In order to access the tax-exempt bond market with a security that will be attractive to investors and provide the lowest possible interest cost, NCMC intends to apply for mortgage insurance from the Federal Housing Administration (FHA) of the U.S. Department of Housing and Urban Development under Section 242 of the National Housing Act. The FHA mortgage insurance will provide credit enhancement for the bonds that will result in bond ratings in the highest rating categories.

In reviewing an application for mortgage insurance, FHA will conduct an evaluation of the project. FHA will issue a commitment to insure a mortgage note under which NCMC will grant FHA a first mortgage lien on the hospital and its revenues and related equipment. Under the FHA program, NCMC will be required to meet certain FHA construction requirements and execute a regulatory agreement containing certain FHA requirements with respect to the operations of the hospital.

VI. Reservation 13 Development and Site Preparation

Overview and Approach to Site Infrastructure

The Anacostia Waterfront Corporation (AWC) was established as the entity charged with the responsibility of revitalizing the Anacostia waterfront. Over the next five years, AWC will facilitate the construction of more than 3 million square feet of new office space, more than 4,500 units of new housing, 32 acres of new public parkland, and a 20-mile riverwalk along both sides of the river. For the NCMC project, AWC's primary responsibility will be to prepare the proposed development site for building construction and to construct the surrounding public infrastructure. Site preparation activities include demolishing existing buildings, abandoning and removing underground utilities, remediating any soil contamination as well as completing preliminary grading. The construction of public infrastructure will include final site grading, and construction of utilities, streets, sidewalks and public parks.

AWC's role with respect to the NCMC project is limited to the preparation of the Reservation 13 project site for NCMC construction. AWC will coordinate site infrastructure improvements to the Reservation 13 site with improvements to the surrounding street and transportation network to ensure the Council-adopted Reservation 13 Small Area Plan is implemented. The off-site transportation improvements that will be necessary to facilitate access to the hospital and other new developments on Reservation 13 will be the responsibility of the District Department of Transportation (DDOT).

Completed Studies

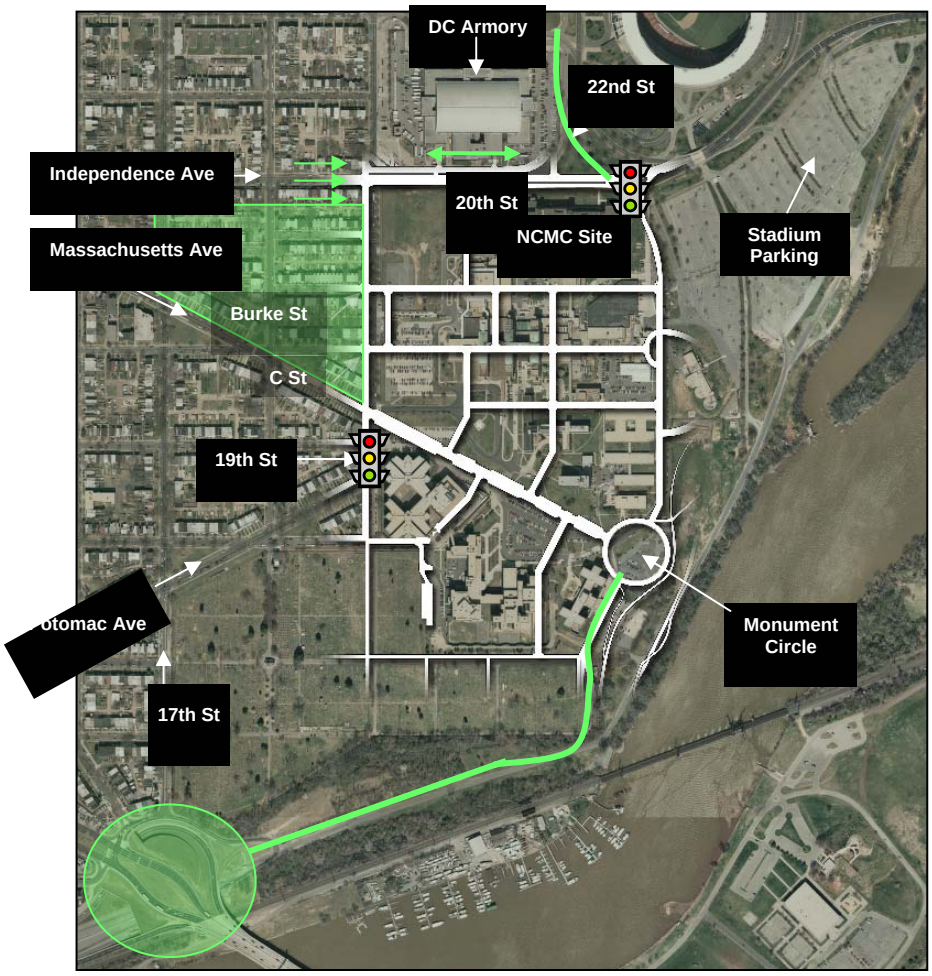
Prior to the proposal to construct the NCMC, the AWC was engaged in the necessary site assessment activities required for site redevelopment. The following represents the due diligence completed by AWC regarding site redevelopment:

- Phase I Environmental Assessment
- Concept Grading Plan
- Concept Utility Relocation Plan
- Concept Street, Streetscape and Public Realm Plan
- Preliminary Cost Estimate for R13 Infrastructure Elements
- Site Engineering and Topographic Survey
- NCMC Project Infrastructure Analysis

In addition, the District Department of Transportation (DDOT) has completed a traffic study to better understand the traffic impacts to the surrounding community and the regional network. The major findings of that study suggest that it will be necessary to make the following off-site arrangements:

- Add a third lane to Independence Avenue during rush hour
- Add a direct connection from 22nd Street to the north to NCMC facility
- Consider two-way operation of Independence Avenue from 22nd Street to the north to 17th Street
- Make improvements to Barney Circle with connection to Hill East Waterfront Park road
- Install traffic calming measures in Hill East neighborhood
- Install traffic signal at intersection of Potomac Avenue and 19th Street, SE

Map of Off-Site Mitigation Strategies



Source: Parsons Brinckerhoff

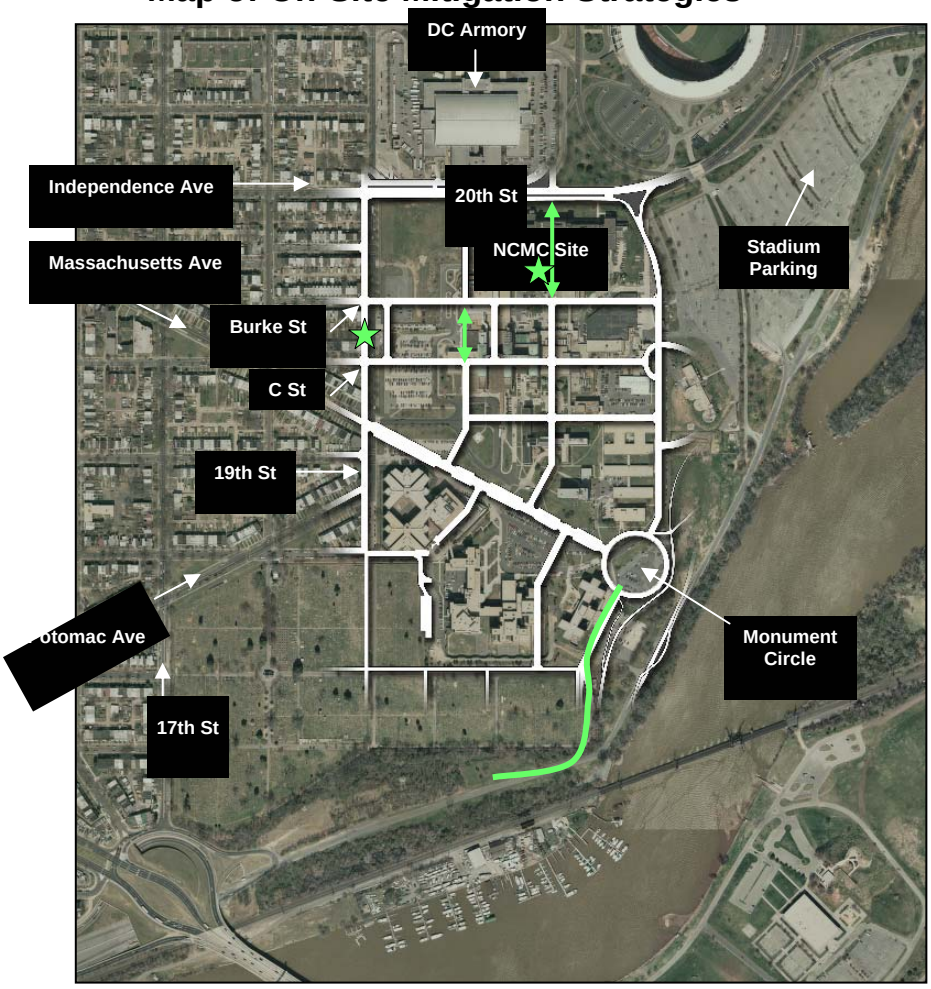
In addition, the DDOT traffic study suggests the following on-site improvements to facilitate access to the site:

- Reconsider the current conceptual plan
  - Open 21st Street within Reservation 13 for improved traffic flows

- Relocate parking garage entrance from Independence Avenue to maintain flow of commuter traffic

- Reconsider Reservation 13 Roadways
  - Extend 20th Street directly from Independence Avenue to Massachusetts Avenue
  - Construct Hill East Waterfront Park Road connection to facilitate access
- Implement travel demand management strategies for the NCMC facility
  - Leverage use of the Metrorail station and bus lines
  - Promote vanpooling/carpooling
  - Price parking as an incentive to use transit
  - Do not overbuild parking

Map of On-Site Mitigation Strategies



Source: Parsons Brinkerhoff

Outstanding Studies

A second phase of Environmental Assessment and Remediation Strategy will need to be completed in order to finish the site development component of the project. The

completion of this assessment will determine the nature and amount of soil contamination, remediation strategy, and the overall costs associated with these activities. These costs have not been estimated to date and are not represented in the overall project budget, due to the fact that they are unknown.

Site Preparation, Site Infrastructure, and Street Improvement Costs
The AWC has estimated the site infrastructure improvements **directly related to the NCMC project** to be as follows:

NCMC Site Preparation and Infrastructure Costs (Millions, in 2005 dollars)	
Hazardous Material Removal	$5 *
Building Demolition	$4
Site Demolition	$1
Site Grading	$2.5
New Street Construction	$5.5
Metro Streetscape Improvements	$1
Hill East Park	$5
Project Contingency and Soft costs	$9
SUBTOTAL	**$32**

* This figure does not account for the unknown soil contamination on the proposed hospital site.

Of this amount, the Council has already appropriated $9M in the FY2005 and FY2005 Supplement Budget Acts for Reservation 13 site infrastructure. This $9M dollar amount represents a significant first step towards the site preparation activities.

The AWC has estimated the total public infrastructure improvements related to the build-out of the **entire** Reservation 13 site to be an additional $48.1 million for a total Reservation 13 site infrastructure investment of $80.1 million. This figure represents site preparation and public infrastructure investments listed in the above categories for the entire 67-acre site, including the extension of Massachusetts Avenue SE from the existing neighborhood to the parklands along the Anacostia River. This figure does not include the unknown soil remediation costs, nor does it include any additional public parking investments the District may or may not chose to pursue.

In addition to on-site infrastructure improvements, DDOT has estimated transportation improvements to the surrounding street network which would facilitate access to the NCMC hospital. These improvements are estimated as follows:

Surrounding Street Improvement Costs (Millions, in 2005 dollars)	
Barney Circle Improvements	$21.3
Hilleast Waterfront Park Road	$4.8
Pennsylvania/Potomac Ave. Intersection	$2.6
Total Street Improvements	**$28.7**

Area-wide infrastructure costs for the NCMC project, the rest of Reservation 13, and related traffic improvements are expected to total $108.8M. The District has agreed to fund 100% of these costs and has to date appropriated $9M to begin NCMC site preparation.

Summary of Total Area-Wide Infrastructure Costs (Millions, in 2005 dollars)

Subtotal – NCMC Site Preparation*	$32
Subtotal – Other Reservation 13 Site Preparation	$48.1
Subtotal - Street Improvements	$28.7
TOTAL AREA-WIDE INFRASTRUCTURE COSTS	**108.8**

* This figure does not account for the unknown soil contamination on the proposed hospital site.

Sources: Site infrastructure estimate based on *Reservation 13 Infrastructure Cost Estimate* prepared by EEK Architects and G&O Consulting Engineers with professional quality assurance review by Accucost Inc. Estimate based on *Reservation 13 Concept Grading and Infrastructure Layout* prepared by G&O and *Reservation 13 Phase I Environmental Analysis* prepared by G&O. All materials prepared in 2004 for the District of Columbia, Office of Planning – Anacostia Waterfront Initiative. Traffic study completed in 2005 for District Department of Transportation by Parsons-Brinckerhoff. Roadway costs are from the Middle Anacostia Crossings Study, District DOT 2005

To prepare the NCMC site for medical center construction, the District has developed the following timeline. A number of key milestones have been identified as "critical path actions" necessary to complete prior to construction. Other milestones can be completed concurrent to NCMC construction.

SITE PREPARATION AND INFRASTRUCTURE SCHEDULE

Critical Path Actions Necessary to Prepare the Site for Construction

Appropriation of Demolition Funds ($9 of $12m)	Summer 2005
Funds Become Available (MOU and Transfer)	December 2005
Procurement of Civil Consulting Services	November 2005
Consultant Selected / AWC Board Approval	December 2005
Completion of Phase II Environmental Report	February 2006
Remediation/Demolition Design Complete	March 2006
Bidding	April 2006
AWC Board Approval of Demolition Contract	May 2006
Relocation of all Uses from Affected Buildings	May 2006
Remediation/Demolition Ground Breaking	June 2006
Site Prepared for Howard University	June 2007

Actions That Can Be Completed Concurrent to NCMC Construction

Funding of Grading, Street and Park Funds ($20M)	TBD
Procurement and Design	8 months
Construction of Grading, Streets and Parks	12-18 months

VII. Zoning Process

The Master Plan for Reservation 13 was approved by the Council on October 15, 2002 and identified four distinct districts on the property that are different in character and use and serve different needs. One of the districts, the Independence Avenue District, is identified for a mix of Citywide Uses and Services, Health Services, Recreation, and Education. The Plan states that ". . . *Sites in this area are also large enough to support the construction of a new hospital, should future need or funding for one be demonstrated."* As part of its adoption of the Master Plan, the Council recommended that an area on the property be reserved for a hospital. The location of the National Capital Medical Center (NCMC) on Blocks B and C is consistent with these recommendations.

Although the D.C. General Hospital was located on Reservation 13, the property was federally owned and was not assigned a zoning category. Therefore, in order to implement the recommendations of the Master Plan, the property must be zoned.

The Office of Planning has recommended the creation of a new Hill East Zone District through the use of form-based coding that will be applicable to all developments on Reservation 13. Form-based coding is a design-oriented format with a Regulating Plan that indicates the desired building forms.

The proposal for the Hill East District was submitted to the District of Columbia Zoning Commission at a public meeting on February 27, 2004 and the Commission voted to proceed towards a public hearing (setdown the proposal). This action by the Zoning Commission vested the proposed zoning, and all proposals will be subject to its recommendations. The proposed zoning text allows hospital use on Blocks A, B, and C, consistent with the recommendations of the Master Plan.

The proposed zoning text states that all projects within the Hill East District shall be considered contested cases and proposed developments must demonstrate how they conform to the Reservation 13 Master Plan and the Hill East Design Guidelines. NCMC will be required to submit a Planned Unit Development (PUD) application to the Zoning Commission for review. The timeframe for PUD review is approximately twelve (12) months.

The following is an outline of the Planned Unit Development approval process:

Planned Unit Development Process

Applicant issues "Notice of Intent to File" 10 days prior to filing application

▼

Application filed at Office of Zoning

▼

Office of Zoning notifies ANC and refers application to Office of Planning (OP) and other City agencies

▼

Setdown Report: OP makes recommendations to Zoning Commission on whether to schedule public hearing

▼

Applicant gives presentation to ANC and possibly other interested groups

▼

Applicant files "prehearing statement" and Office of Zoning schedules public hearing – typically about 60 after prehearing statement filed

▼

OP coordinates information from other city agencies, such as DDOT, DPW, Police, Fire, Parks

▼

OP works with applicant, ANC and other neighborhood groups to resolve any outstanding issues

▼

ANC makes recommendation to Zoning Commission regarding project

▼

OP issues final report and recommendation to Zoning Commission at hearing

▼

Public Hearing held at Zoning Commission

- Applicant presents project
- OP gives report & recommendation
- ANC and other parties give testimony & recommendation
- Supporters and opponents give testimony

▼

Proposed Action typically at next regular meeting – published in DC Register and written comment received for 30 days after publication

▼

Proposed Action Referred to NCPC for 30 day comment period – public comment also taken

▼

Final Action taken at next regular meeting and becomes effective 10 days after final action

VIII. Certificate of Need

The Certificate of Need (CON) process is a mechanism used by state governments based on the theory that it will control the costs of health care by regulating the supply. In 1974, the Federal government imposed the National Health Planning and Resources Development Act, which mandated Certificate of Need programs and provided that certain federal funds were contingent on a state's establishment of CON. The climate at the time was one of skyrocketing health care costs, and Congress enacted this law as an attempt to reduce national costs. The National Health Act was repealed in 1986 because lawmakers found that this mechanism failed to effectively control costs.[1]

Since that time many states have reduced or completely eliminated their CON programs. The following 14 states do not have a CON process at all: Arizona, California, Colorado, Idaho, Indiana, Kansas, Minnesota, New Mexico, North Dakota, Pennsylvania, South Dakota, Texas, Utah, and Wyoming. Four states have limited the CON process to no more than two services. An additional eight states (Missouri, Oklahoma, Arkansas, Wisconsin, Oregon, Ohio, Nebraska, and Louisiana) do not mandate CON for acute care or ambulatory surgical centers.[2] The Federal Trade Commission and Department of Justice issued a report in July 2004, based on a series of 27 hearings and workshops with experts, which recommended that states reconsider their CON process on the basis that it does not control health care costs and is used by market incumbents to create barriers to competition.[3] The American Medical Association also took an official stance in December 2004, encouraging states to limit the use of the CON process.

By law, health facilities in the District must apply for and receive a CON prior to commencing any new construction project and/or providing new services. However, the Council may through legislation exempt a health facility from the CON process, and there is precedent for such an exemption. An exemption was granted in September 2000 for the closure of DC General and the transfer of some of its services to Greater Southeast Hospital. In addition, an exemption was granted when Doctors Community acquired Greater Southeast Community Hospital in December 1999.

The City Administrator's Office is recommending that the National Capital Medical Center legislation seek a legislative exemption from the CON process for the construction of the new NCMC and for any transfer of services from Howard University Hospital to the NCMC, so long as total operating beds of the two hospitals do not exceed Howard

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[1] McGinley, Patrick J. Beyond Health Care Reform: Reconsidering Certificate of Need Laws I a Managed Competition System 1995 Florida State University Law Review. http:://www.law.fsu.edu/journal/lawreview/issues/231/mcginley.html

[2] American Health Planning Association. 2005 National Directory of Health Planning, Policy, and Regulatory Agencies, 15th Edition.

[3] Federal Trade Commission and Department of Justice Antitrust Division. Improving Health Care: A Dose of Competition. July 2004.

University Hospital's current license of 482 beds. The proposed legislation is included in Appendix D.

The rationale for this exemption is that the NCMC is not a typical CON project. By the time this project makes it through the Council process it will have already undergone much more scrutiny than would occur in a typical CON process, with at least four public hearings, multiple public analyses, and at least three Council votes. Multiple interest groups will have commented and issued their own opinions on the numerous analyses already presented by the District and Howard University. Moreover, the CON process itself is a multi-stage process involving multiple appeals that could take as long as five years. Even if passed by a Council majority and signed by the Mayor, the NCMC project could easily be stalled by the CON process. In addition, the CON process would add an additional $300,000 to the budget.[4]

The CON process is as follows:

- Public Advertisement/ Letter of Intent to State Health Planning and Development Agency (SHPDA)/ Pre-application consultation
- Submit application (15 -30 days to declare application is complete)
- SHPDA review begins (90 days)
    - Staff report
    - Public Hearing
    - Project Review Committee/Statewide Health Coordinating Council (SHCC) recommendation
    - SHPDA Director (Deputy Director at Department of Health) approves/denies
- 1st Appeal (45 days)
    - Applicant or other interested parties may request reconsideration
    - Required Public reconsideration Hearing
- 2nd Appeal: Board of Appeals and Review (BAR) (75 days or more, can proceed for years)
- 3rd Appeal: DC Court of Appeals (establish their own timeline)
- Final Appeal: Appeal to the US Supreme Court[5]

The Certificate of Need process requires that each facility or service meet the following criteria, published by SHPDA:

[4] District of Columbia, Department of Health State Health Planning and Development Agency Certificate of Need Review Division.
[5] Id.

Need
The need for services addresses the adequacy of health care services that are currently available and the type, amounts and levels of service that should be available to meet the aggregate need. In determining the need for services, the State Health Planning and Development Agency (SHPDA) asks questions such as the basis for the need to establish new or expanded services, the reasons why the need cannot be met by existing providers, and whether the proposed services will be able to meet the demonstrated need for services.

Accessibility
Accessibility is the measure of an individual's or group's ability to obtain needed services. It addresses factors that either enhance or inhibit a patient's ability to get to where the services are located and to receive timely and appropriate services. It is associated with such issues as hours of operation, location, distance, environmental or physical barriers, and financial accessibility (affordability). It also addresses the need that residents should be able to received services regardless of sex, race, color sexual orientation, socio-economic statues, cultural background, method of payment or ability to pay.

Quality
The quality criteria and standards deal with the level of excellence of the proposed services. The measures include the qualifications of staff, the existence and extent of quality control mechanisms, the appropriateness of services, the documentation of treatment provided, the ability to meet recognized standards of care, and the ability to keep pace with advancements in health care knowledge and techniques.

Acceptability
Acceptability is a measure of the degree to which patients may be satisfied with the services they receive. Issues addressed include operating policies, personnel capabilities, involvement of the community in the planning and development of the proposed project, and the physical and environmental condition of the facility. It also deals with such issues as the patient bill of rights, grievance procedures, and procedures for the explanation of problems and treatments that follow.

Acceptability also deals with the level of community involvement and participation in the preparation and development of the proposed project, and the adequacy of the public notice that the applicant provided to the affected ANC. This is important not only because it enables the community to know what services are being established in their neighborhood but also provides them a forum to be involved in the decision making process.

Continuity
The criteria and standards for continuity of care deal with issues regarding patient and medical information transfer, follow-up procedures, patient care plans, and maintenance of medical records. Applicants are required to establish transfer agreements between providers of primary, secondary and tertiary levels of care as well as between different services providers with the same level of care. Applicants are also encouraged to establish services with other social service delivery systems in the community in order to ensure that patients receive the range of services that they require. Continuity of care measures the ease with which patients are moved into various levels of care and the degree to which the referral system is integrated.

Financial Viability
The issues addressed here include the financial ability of the applicant to establish and operate the services and the long-term financial viability of the proposed project. In other words, does the applicant have the resources to cover any proposed capital expenditures or any deficits, and will the facility be able to generate more revenues than expenses?

In addition, the CON law and regulations require health care providers to provide uncompensated care to needy patients in an amount at least equal to three (3%) percent of the CON holder's operating cost. CON applicants are required to certify that they will meet the requirements.

The following is a brief summary of how the NCMC meets the CON criteria:

Need
The need for the hospital has been evidenced by the unequal distribution of hospital beds on the eastern side of the District (detailed in July NCMC Proposal). Currently, there is only one hospital on the east side of the District to serve the most densely populated neighborhoods in the District. These neighborhoods are underserved and have the highest concentration of families living below 200% of the Federal Poverty Level, children under 18, and adults suffering from chronic conditions. A disproportionate number of emergency calls originate from the neighborhoods that will be served by the NCMC. The NCMC will ensure a more appropriate distribution on medical resources by adding services for residents on the east side of Washington, DC.

Accessibility
The NCMC will be situated to meet the needs of the currently underserved and will better distribute District hospital services geographically. The NCMC will add a Level 1 Trauma Center on the east side of the District, so patients will no longer have to be transported across town to receive the most acute emergency services. The proposed location on Reservation 13, adjacent to major freeways and bridges, is praised by District EMS officials as one of the most accessible sites for ambulances. In addition, the NCMC will be several blocks from a metro station and is served by six metro bus lines. NCMC

and its faculty physicians will build on Howard University Hospital's record and welcome Medicaid, Alliance, and uninsured patients.

Quality
The NCMC will be an all digital hospital with state-of-the-art medical equipment, patient safety and clinical information systems. This academic teaching facility will be the home to distinguished Howard University faculty physicians with expertise in a number of specialty areas. There will be a research center on aging, clinical information systems, and nursing.

Continuity of Care
NCMC will serve as a major hub in an integrated system of care to provide residents with access to primary, preventive, specialty, and inpatient care. NCMC will work closely with the Medical Homes Initiative to ensure strong relationships and appropriate referral mechanisms between the NCMC and nearby community health centers. NCMC will work closely with District electronic medical record initiatives to ensure HIPAA-compliant exchange of patient health data.

Acceptability
Overall, the NCMC will meet many of the needs of the community by strengthening public access to health care. A medical office building will house community physicians so that patients may be seen by a doctor that they are familiar with. The NCMC will boost the economy of the surrounding neighborhood. The hospital will spur economic development, with at least 500 new jobs on the east side of the District, and jobs will also be created through the construction of the hospital itself. The NCMC will be equipped to serve the District in the event of a disaster, and it will be located apart from many of the District's other major hospitals in the event that all hospitals in one part of the city are incapacitated or inaccessible.

Financial Viability
The District of Columbia and Howard University will each provide 50% of the funds to construct the hospital. Based on projections from Howard's financial reports, the NCMC is expected to have a positive operating margin after several years of ramp-up. Howard University has agreed to provide working capital to cover the expected losses in the first several years of operation. (See July 2005 NCMC proposal for operating financial statements.)

IX. Public Health Services and Site Redevelopment

The Council-adopted Hill East/Reservation 13 Small Area Plan calls for the consolidation of healthcare uses on the site into better planned and more functional buildings that more efficiently utilize the land on Reservation 13. The redevelopment of the site will result in the demolition of most of the existing buildings on the campus, most of which are in sub-standard or neglected condition. A number of the buildings house key District public health services, though most of these facilities are in need of major renovation or relocation. This provides the opportunity to modernize the District's public health facilities to improve delivery of services. In addition, it provides new redevelopment opportunities, which allow for a new mixed-use neighborhood to emerge on Reservation 13. The City Administrator's office, working with the Office of Property Management and Anacostia Waterfront Corporation, has developed a strategy to address these existing public health services:

Chief Medical Examiner and Laboratories

The Office of the Chief Medical Examiner (morgue) will be combined with the Consolidated District Laboratory project. This new state-of-the-art laboratory will co-locate the District's public health, environmental, and forensic/criminal labs. The public health labs will have Bio-Level III capabilities for emergency preparedness, meaning that if any suspicious substance is discovered in the District, the lab personnel and lab physical facilities will be capable of safely evaluating the substance. The entire Consolidated Laboratory will be relocated away from Reservation 13. The District is considering several sites for the project.

Public Health and Substance Abuse Services

A second set of health services will be relocated to a new District-government facility proposed to be on "Site L" of the Reservation 13 site plan, which is immediately in front of the existing jail building along the southern side of the extension of Massachusetts Avenue. This location is consistent with the Hill East Master Plan, which allows residential, health services, civic buildings, municipal offices, as well as correctional facilities along the Massachusetts Avenue corridor. It also meets the wishes of many community members that participated in the Hill East planning process, who preferred to locate government and institutional uses South of Massachusetts Avenue, on a site that mitigates the negative architectural impact of the jail facilities on the surrounding neighborhood.

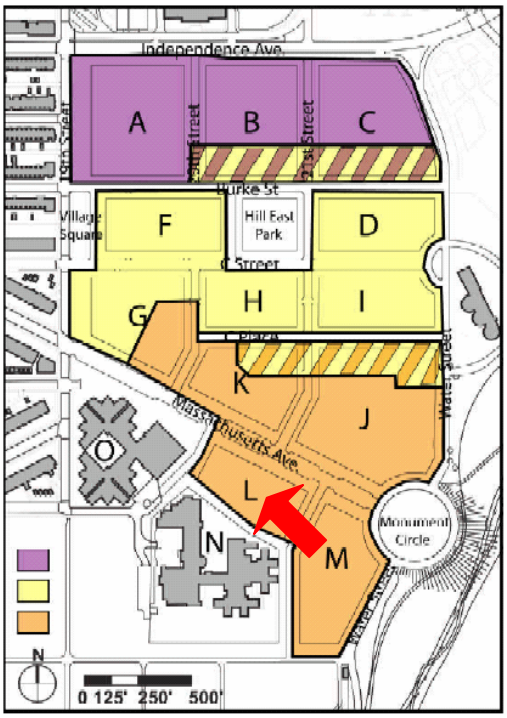
This new building will house the Sexually Transmitted Disease and Tuberculosis Clinic, and key substance abuse and detox facilities (including the women's methadone clinic), managed by the Department of Health. The size of the STD and TB clinics is estimated at 38,000 square feet and the substance abuse facilities at 60,000 square feet. There are no plans to transfer any additional public health services that do not already exist on the current site. The new facility will provide a setting more conducive to the provision of

care. We estimate that these public health services will take up to about 98,000 square feet of space.

The total potential build-out of "Site L" is larger than the needed space for public health services. AWC has estimated a total development potential of up to 325,000 gross square feet, based upon the assumed size of the parcel being approximately 46,000 square feet and assuming a building design with seven floors in height. Because leases for approximately 1 million square feet of District government office space are expiring between now and 2008, there is an opportunity to relocate a number of government offices to a more cost-effective location. It is anticipated that District government office space, perhaps the Department of Health or the Department of Corrections, could be relocated to Site L, in addition to the public health services.

A likely project development scenario would be for the District's Office of Property Management to enter into a lease with the AWC for this building. The AWC could utilize the lease agreement with the District to privately finance the building construction through private developer procurement. Given the intention to redevelop other adjacent parcels on the Reservation 13 site, the AWC might also be able to leverage this development action in concert with other office and residential development on the Reservation 13 site. The AWC, as sub-lessor, would sub-lease the land to a third party for the purpose of financing and constructing a municipal building. It is estimated that a 325,000 square foot municipal building would cost approximately $93 million. The District will agree to enter into a long-term lease for the entire building in order to provide security for the financing. The building lease will be structured in such a way that the District will own the building at the end of the lease term. The land lease will be structured in such a way that it will terminate when the District owns the building.

RESERVATION 13 MASTER PLAN



Independence Avenue District
City-wide uses and services
Residential
Health Services
Recreation
Education

C Street Neighborhood
Residential
Health Services
Community Amenities
Neighborhood Retail

Massachusetts Avenue District
Residential
Health Services
Civic Buildings
Municipal Offices
Correctional Facilities

Proposed Public Health/District Government Office Building

Urgent and Specialty Care Services

In addition, an urgent care clinic and a set of ambulatory care (specialty) clinics are currently operated on the Reservation 13 site by Greater Southeast Community Hospital as a provision of the DC Healthcare Alliance contract. Similar services will eventually be provided on the site by the new National Capital Medical Center and its adjoining medical office building. The District is currently undertaking an analysis of the cost and utilization of the existing clinics. The District is also holding discussions with Greater Southeast about how to continue these services on a different site once the Alliance contract expires and once the current facility must be demolished to make way for construction of the NCMC. The services may transition to a location on the east side of the Anacostia River. The District has agreed to sign a Memorandum of Understanding (MOU) with Greater Southeast Community Hospital to work on the master plan of their campus in Ward 8. Consistent with that MOU, the District will explore the option of locating some public health services on that site (See Chapter X and Appendix E).

In addition, Reservation 13 currently houses the District's mental health crisis unit (CPEP), which evaluates patients thought to have mental illness to determine the most appropriate treatment setting. This facility will eventually be housed within the NCMC, adjacent to its emergency department, since many mentally ill patients must also be physically evaluated. The District is still working to identify an interim home for CPEP while the NCMC is constructed.

X. Greater Southeast Community Hospital MOU

Greater Southeast Community Hospital experienced financial challenges over the past several years prior to any discussion of the NCMC, though it was once a thriving institution, even when both DC General and Capital Hill Hospital were in existence as competitors. Under the leadership of Joan Phillips, Greater Southeast has been able to regain its accreditation and significantly improve operations. The Administration has been assured that the facility now has a positive operating margin and is in no danger of shuttering.

In July, District officials met with the ownership of Greater Southeast and agreed to participate in the hospital's campus master planning process. The District and Greater Southeast agreed to sign a Memorandum of Understanding (MOU), which states that the District will work cooperatively on the campus master planning effort. Under the terms of this MOU, the District and Greater Southeast will exchange information and data on the planning for the National Capital Medical Center and Greater Southeast's strategic facility planning in order to avoid duplication of effort in addressing the healthcare needs of the community on the east side of the District. In addition, the District and Greater Southeast will coordinate planning for the opening of the National Capital Medical Center to provide adequate time for Greater Southeast to mitigate any impact of the NCMC on its programs and services. Finally, the District and Greater Southeast will explore opportunities to pursue public/private partnerships to provide public health services on the campus of Greater Southeast. (See Appendix E for draft MOU)

The Mayor is committed to working closely with Greater Southeast, its patients, and its employees. The District is in close communication with the leadership of Greater Southeast about issues such as the Alliance contract and the Corrections contract. The MOU establishes a Joint Planning Committee to review and coordinate plans for each facility to ensure that the health care needs of the community are met.

XI. **Medical Homes Update**

A positive side-effect of the National Capital Medical Center proposal is that it has raised awareness and concern about the high rates of chronic illness in the District of Columbia. Both supporters and critics of the hospital have pointed out that there is a significant need to expand access to primary care, especially in underserved areas. Currently, many neighborhoods in the District have a shortage of primary care providers. This lack of local private physicians and community health centers contributes to lower health status in the District because residents do not have adequate access to routine preventive services and care for their chronic conditions. As a result, they are more likely to delay medical care until they experience an emergency. This leads to worse health outcomes and higher costs for the District and Federal governments, which pay for the health coverage of roughly one-third of District residents. The Administration strongly supports the goals of expanding access to primary care in underserved areas and of improving the clinical quality of the primary care safety net.

The Medical Homes DC initiative was first proposed to the Mayor in late 2003 by the DC Primary Care Association (DCPCA) and the Brookings Institution. The Mayor embraced the Medical Homes proposal and committed $21 million to the effort. Since then, the District has been working closely with DCPCA and its partners to design and implement the initiative.

A Medical Home is a primary care community health center serving lower income people at which a patient's health history is known, where he or she will be seen regardless of ability to pay, and where he or she routinely seeks non-emergency care. The goal of Medical Homes is to invest in the physical, clinical, and management infrastructure of the District's nonprofit community health care centers so they can offer more high quality primary care, such as regular preventive check-ups and care for chronic conditions like diabetes and high blood pressure. The Medical Homes DC initiative offers grants to nonprofit community health providers to build new health centers or renovate existing facilities. In addition, Medical Homes has just started to offer significant training and technical assistance to health centers throughout the District to help them improve their clinical quality and management systems. District-based community health centers that meet key quality and management criteria will become "Certified Medical Homes", a designation that will assure patients of high quality care, and may eventually be tied to higher reimbursements from District government health coverage programs.

According to the District's grant agreement with DCPCA, the District has provided $1 million in FY05 capital dollars and will provide $7 million in FY06 and another $7 million in FY07. DCPCA has agreed to raise at least 50% matching dollars for this project from private sources. To date the Medical Homes initiative has experienced significant fundraising success with local foundations and is now seeking the support of national foundations. In addition to the capital contribution, the FY06 budget includes

another $1.8 million grant to DCPCA to cover the operating costs of the program, specifically many of the technical assistance activities that will improve the quality of care delivered at DC health centers.

In October, the Mayor announced the first nine Medical Homes capital projects, which were chosen through a grant process managed by DCPCA. Nine grants were awarded to seven different community health centers for sites in Wards 1, 4, 5, 6, 7, and 8. The recipients of these grants are, as follows:

- Unity Healthcare is the recipient of two preconstruction grants, one for a new Anacostia Health Center in Ward 8 and one for a new Hunt Place Health Center in Ward 7;

- Family & Medical Counseling is the recipient of a preconstruction grant to expand its health center in Ward 8;

- Bread for the City is the recipient of two preconstruction grants, one for a new health center site in Ward 5 and another to expand its current site in Ward 2;

- Mary's Center for Maternal & Child Health is the recipient of a preconstruction grant to expand its newly opened health center in Ward 4;

- Community of Hope is the recipient of a preconstruction grant to expand its health center in Ward 1;

- La Clínica del Pueblo is the recipient of a preconstruction grant to expand its facility in Ward 1; and

- So Others Might Eat is the recipient of a construction grant to expand its dental services in Ward 5.

Most of these projects received relatively small preconstruction grants to plan for new facilities and renovation. Once all planning milestones have been met, these projects will be eligible for additional funding for construction. DCPCA will hold a second grant application process in Spring of 2006, and will accept applications for new projects. Within the next several years, District residents will begin to see new primary care clinics opening in their neighborhoods as a result of the Medical Homes initiative.

XII. Health Care Coverage: 200-400% FPL

Questions have been raised about how the National Capital Medical Center will serve the uninsured population in DC and whether a significant number of uninsured patients will jeopardize its financial viability. We believe that the National Capital Medical Center, like most hospitals in the District, will be well-compensated for most patients that it sees, with few uncompensated patients. And we intent to propose legislation that will further reduce the number of uninsured patients in DC.

The District has made a stronger commitment than any other jurisdiction in this country to provide health coverage for its residents. The DC Medicaid program offers coverage to all Medicaid-eligible residents (children, parents, elderly, and disabled) up to 200% of the federal poverty level. In addition, the District offers coverage through the DC Alliance program to childless adults and undocumented residents under 200% of the federal poverty level. As a result, all DC residents under 200% of poverty are eligible for comprehensive health coverage.

We have made an attempt to determine exactly how many uninsured residents reside in DC. While there are no perfect data sources, the best available data comes from a recent study by the Urban Institute (UI), which was completed as part of the District's State Planning Grant for Coverage of the Uninsured. This study was based on federal government Current Population Survey data. In order to get enough data to achieve statistical significance, UI combined three years of data, from 2001-2003.

The study found that approximately 73,714 residents of the District of Columbia did not have health insurance over the years of 2001 to 2003. Of this total, 68% (50,026 people) had incomes between 0% and 200% of poverty. It is important to note that the study time period spans the initial start-up of the Alliance program, which began operation in 2001. The population of the Alliance program has grown significantly over the past few years, so this study likely overstates the number of uninsured below 200% of poverty.

Under the Medicaid and Alliance programs, no resident of the District of Columbia with an income under 200% of poverty should be without coverage. In practice, we know that some individuals within this income bracket do not proactively enroll in coverage programs. However, many of them actually become enrolled when they seek care in a District hospital or community health center. The management of those facilities has a very strong incentive to see that eligible patients enroll, so the facility can be paid for their services. As a result, most eligible uninsured individuals become enrolled at the time of service, ensuring payment for the healthcare provider. Thus, we can conclude that the National Capital Medical Center, like other hospitals in the District, will receive reimbursement for most patients who are DC residents with incomes below 200% of poverty.

The UI study also found that 14,455 District residents, about 2.5% of the total District population, are between 200% and 400% of poverty and uninsured. When these uninsured individuals seek care in District hospitals, they are frequently sent large medical bills, which they find very difficult to cover. As a result, health facilities frequently do not receive payment for those services. The District, through the federal Medicaid Disproportionate Share Hospital program (DSH), compensates hospitals for uninsured patients. Each DSH hospital receives a lump sum payment every year based on its reported uncompensated care costs. The District makes roughly $35M in DSH payments to District hospitals annually.

In addition, the study found 9,243 uninsured District residents over 400% of poverty. This category includes individuals who could likely afford health insurance, but have chosen not to purchase it for various reasons. Individuals in this category are likely to be disproportionately young and healthy, so they are unlikely to contribute significantly to hospital uncompensated care costs.

This Administration has a goal of continuing to expand health coverage in the District. Now that we offer coverage to all residents under 200% of poverty, we can address those who are between 200% and 400%. This population, though relatively small, is of concern because individuals in this income category probably earn too little to easily afford health insurance. In the next few years, our goal is to expand coverage for those who are 200-400% FPL, and this Fall the Mayor will propose legislation that will raise the funds to subsidize the health premiums of individuals in this category. The proposed legislation will increasing the gross premium tax on CareFirst Blue Cross Blue Shield up to 1.7%, the same level as other health insurers that operate in the District (See Appendix F for legislative language). This will generate roughly $5M in new revenues annually, and this amount will increase as health premiums rise over the years. Additionally, the District may be able to leverage additional federal dollars through the Medicaid program, potentially brining the total new revenues available for health coverage to $15M annually.

The District could implement various different programs to provide coverage to moderate income individuals. The Administration supports the expansion of free coverage to children up to 400% of poverty. In addition, we are evaluating different alternatives for subsidizing health coverage for adults in the 200% to 400% FPL income category. For example, we could allow residents with moderate incomes to buy into Medicaid or the Alliance. Alternatively, we could implement a reinsurance pool to help reduce the market price of private insurance, a successful program in New York State. Councilmember Catania has introduced such a proposal. The District's State Planning Grant Advisory Committee on Coverage for the Uninsured will be making its recommendation by the end of the year. We look forward to the results of that committee's work, and expect to introduce or support legislation to expand coverage in early 2006.

Uninsured District Residents

Family Income as percent of FPL	Number of Uninsured	Percent of Uninsured population	Percent of District population
0-99	31,576	43%	5.5%
100-199	18,450	25%	3.2%
200-399	14,445	20%	2.5%
400+	9,243	13%	1.6%
TOTAL	**73,714**	**100%**	**12.9%**

Source: Urban Institute, Projected from 3 yrs of Current Population Survey data, 2001-2003

XIII. Next Steps

The District and Howard University are working toward finalizing an Exclusive Rights Agreement (ERA), which will govern the terms of the partnership between the two parties. Appendix A includes a draft version of the ERA, which is still subject to negotiation. Appendix G includes a letter that was sent from the Mayor to the President of Howard University outlining key next steps. Once language has been finalized, and Howard University's Board of Trustees has approved the agreement, the Mayor will introduce the ERA for Council Approval.

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Any questions or comments on this supplemental document or the NCMC project in general should be directed to:

The District of Columbia
Gina M. Lagomarsino, Senior Policy Advisor
The Office of the City Administrator
gina.lagomarsino@dc.gov
(202) 727-1754

Howard University
Diane E. Kenney, Chief of Staff
The Office of the Senior Vice President
dkenney@research.howard.edu
(202) 806-2530